



New Jersey Office of the Attorney General

Division of Consumer Affairs
New Jersey Board of Nursing
124 Halsey Street, 6th Floor, P.O. Box 45010
Newark, New Jersey 07101
(973) 504-6430
www.NJConsumerAffairs.gov/nursing

**Board of Nursing Instructions to Apply for
Reinstatement of Advanced Practice Nurse Certification**

In accordance with the Uniform Enforcement Act, a professional or occupational license or certificate of registration may be reinstated, provided that the applicant otherwise qualifies for licensure, registration, certification and complies with the provisions of N.J.S.A.45: 1-7.2 a, b, c and d. The necessary application and materials for applying for reinstatement are enclosed.

1. Complete and return to:

New Jersey Board of Nursing
P.O. Box 45010
Newark, NJ 07101

2. Submit the following:

☐ **Application:**

Complete the enclosed application and have it notarized.

☐ **Fees:**

Payment of a reinstatement fee of \$100 and the Certificate Renewal Fee of \$160 for a total of \$260 sent as either a check or money order to the New Jersey Board of Nursing.

☐ **Employment Certification:**

An affidavit of employment listing each job held during the lapsed licensure or certification period. This affidavit of employment must include the names, addresses and telephone numbers of each employer.

A notarized statement indicating if you were engaged in the practice of your profession or occupation in New Jersey during the period that your New Jersey license or certificate was lapsed. If you were practicing your profession or occupation during this lapsed license period, you must include a description of the type of work or projects with which you were involved.

☐ **Certification and Authorization Form for a Criminal History Background Check.**

☐ **Continuing Education Compliance Report Form:**

Satisfactory proof that the applicant has maintained proficiency by completing the continuing education hours or credits required for the renewal of an active license or certificate of registration or certification.

Attach a clear, full-face passport-style photograph (2"x 2") of your head and shoulders, taken within the past six months, with your name printed on the back of the photo.

A photo is required with each application.

Do not use staples to attach the photo.



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A.P.N. License Number

Area of Clinical Specialty

Application to Reinstate Advanced Practice Nurse Certification

Along with the submission of this completed application, all fees must be paid in the form of a check or money order made out to the State of New Jersey. The fee(s) must be submitted with this application for reinstatement (applicants should understand that if the fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the reinstatement process will be delayed until the fee is paid).

The Division is precluded by law from disclosing to the public the place of residence of licensees or applicants, without their consent. However, you are required to provide an address that may be released to the public in our directories or in response to other requests (by putting a check in the appropriate box). If you provide your place of residence as your public address of record, we will assume that you have consented to have that address be disclosed. If you do not consent to the disclosure of your place of residence, you should provide an address of record other than your place of residence that may be released to the public. One of your addresses must include a street, city, state and ZIP code.

Information that you provide on this application (including your address of record) may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

Date of birth: _____
Month Day Year

1. Name _____
Last name First name Middle name Maiden name

2. Address

☐ Home: _____
Street or P.O. Box City State ZIP code County

Telephone number (include area code) E-mail address

☐ Business: _____
Name of company Telephone number (include area code)

Street City State ZIP code County

☐ Mailing: _____
Street or P.O. Box City State ZIP code County

3. *Social Security No: ____ - ____ - ____

You **must** provide your Social Security number to the Board. Failure to do so will result in denial of licensure reinstatement.

*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7, 60.8 and 60.9, the Board is required to obtain your Social Security number. Pursuant to these authorities, the Board is also obligated to provide your Social Security number to:

- a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;
- b. the Probation Division or any other agency responsible for child support enforcement, upon request; and
- c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses, registrations or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

- ☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

5. Student Loan

Are you in default in regard to any student loan obligation(s)? ☐ Yes ☐ No

If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issued your student loan, for the eventual repayment of the loan. You will not be able to obtain a license or certificate unless you provide the required documents concerning the plan for repayment of your student loan.

6. Child Support

Please certify, under penalty of perjury, the following:

- a. Do you currently have a child-support obligation? ☐ Yes ☐ No
 - (1) If "Yes," are you in arrears in payment of said obligation? ☐ Yes ☐ No
 - (2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months? ☐ Yes ☐ No
- b. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No
- c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No
- d. Are you the subject of a child-support-related arrest warrant? ☐ Yes ☐ No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to questions a(1) through d will result in a denial of reinstatement of licensure. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

Applicant's name (please print)

Applicant's signature

Date

7. Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

For the purposes of these questions, the following phrases or words have the following meanings:

“Ability to practice your profession” is to be construed to include all of the following:

- The cognitive capacity to exercise the reasonable judgments of an advanced practice nurse, and to learn and keep abreast of professional developments;
- The ability to communicate those judgments and related information to patients and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and
- The physical capability to perform the duties of an advanced practice nurse, with or without the use of aids or devices, such as corrective lenses or hearing aids.

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

“Chemical substance” is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

“Currently” does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, or within the previous two years.

“Illegal use of controlled dangerous substance” means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No
- Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**? ☐ Yes ☐ No ☐ Not applicable
- Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? ☐ Yes ☐ No ☐ Not applicable
- Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No ☐ Not applicable
- Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? ☐ Yes ☐ No
- Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that “currently” is defined as “within the last two years.”) ☐ Yes ☐ No

If you answered “Yes” to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☐ No

** If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure reinstatement.

8. Have you ever changed your name? ☐ Yes ☐ No

If "Yes," please submit with this application a copy of the marriage certificate, divorce decree or court order.

9. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Parking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

10. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. ☐ Yes ☐ No

If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

11. Do you currently hold, or have you ever held, a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please provide that name.

	Last name	First name	Middle initial
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired
Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expire

12. Have you ever been disciplined or denied a nursing license or certificate of any kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

13. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

14. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

15. Have you ever been named as a defendant in any litigation related to the practice of nursing or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

16. Are you aware of any investigation pending against a professional license or certificate issued to you by a professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

17. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

18. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional group related to the practice of nursing or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

If the answer to any of the above questions, numbers 12 through 18, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of: _____

County of: _____

} ss.

I, _____, in making this application to the New Jersey Board of Nursing for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the New Jersey Board of Nursing, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a license or certificate issued by the Board.

I further swear (or affirm) that I have read N.J.S.A. 45:11-23 et seq., together with the Rules and Regulations of the New Jersey Board of Nursing, N.J.A.C. 13:37, and fully understand that in receiving licensure or certification from the Board, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board.

Signature of applicant

Sworn and subscribed to before me this _____

day of _____, _____
Month Year

Name of Notary Public (please print)

Signature of Notary Public

Affix Seal Here



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Employment Certification for the Reinstatement of a Lapsed License

Directions: Please complete this certification, sign and date it and return it to the New Jersey Board of Nursing. If you have had more than two employers, please add additional sheets of paper with the employment data. The Board may contact your employer(s) to verify your employment.

_____ <i>First name</i>	_____ <i>Middle name</i>	_____ <i>Last name</i>	_____ <i>Maiden name</i>
_____ <i>Present Street Address</i>	_____ <i>City</i>	_____ <i>State</i>	_____ <i>ZIP Code</i>
<input type="checkbox"/> <i>R.N.</i>	<i>License No.</i> _____		
<input type="checkbox"/> <i>A.P.N.</i>	<i>Certificate No.</i> _____		

Employment Data: (For the past five (5) years in New Jersey or in any other jurisdiction.)

1.	_____ <i>Name of employing agency or facility</i>			
	_____ <i>Street address</i>			
	_____ <i>City</i>	_____ <i>State</i>	_____ <i>ZIP Code</i>	
	_____ <i>Job Title</i>	_____ <i>Employment Dates:</i>		_____ <i>From</i> <i>To</i>
	_____ <i>Supervisor's name</i>	_____ <i>Title</i>	_____ <i>Telephone No. (include area code)</i>	
2.	_____ <i>Name of employing agency or facility</i>			
	_____ <i>Street address</i>			
	_____ <i>City</i>	_____ <i>State</i>	_____ <i>ZIP Code</i>	
	_____ <i>Job Title</i>	_____ <i>Employment Dates:</i>		_____ <i>From</i> <i>To</i>
	_____ <i>Supervisor's name</i>	_____ <i>Title</i>	_____ <i>Telephone No. (include area code)</i>	

3.

<hr/>			
<i>Name of employing agency or facility</i>			
<hr/>			
<i>Street address</i>			
<hr/>			
<i>City</i>	<i>State</i>	<i>ZIP Code</i>	
<hr/>			
<i>Job Title</i>	<i>Employment Dates:</i>	<i>From</i>	<i>To</i>
<hr/>			
<i>Supervisor's name</i>	<i>Title</i>	<i>Telephone No. (include area code)</i>	

4.

<hr/>			
<i>Name of employing agency or facility</i>			
<hr/>			
<i>Street address</i>			
<hr/>			
<i>City</i>	<i>State</i>	<i>ZIP Code</i>	
<hr/>			
<i>Job Title</i>	<i>Employment Dates:</i>	<i>From</i>	<i>To</i>
<hr/>			
<i>Supervisor's name</i>	<i>Title</i>	<i>Telephone No. (include area code)</i>	

5.

<hr/>			
<i>Name of employing agency or facility</i>			
<hr/>			
<i>Street address</i>			
<hr/>			
<i>City</i>	<i>State</i>	<i>ZIP Code</i>	
<hr/>			
<i>Job Title</i>	<i>Employment Dates:</i>	<i>From</i>	<i>To</i>
<hr/>			
<i>Supervisor's name</i>	<i>Title</i>	<i>Telephone No. (include area code)</i>	

<hr/>	<hr/>	<hr/>
<i>Applicant's name (Please print)</i>	<i>Applicant's signature</i>	<i>Date</i>



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New Jersey Board of Nursing

124 Halsey Street, 6th Floor, P.O. Box 45010

Newark, New Jersey 07101

(973) 504-6430

Continuing Education Compliance Report Form

Name: _____ R.N. License Number: _____

I certify that the foregoing statements made by me are true to the best of my knowledge. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment, including but not limited to suspension or revocation of a license and/or certification under N.J.S.A. 45:1-21.

Signature: _____

Title of Program Attach copies of the certificates*	Date	Program Provider	Contact Hours
A total of 30 contact hours is required.			Total _____

*Attach a copy of the program certificate of completion/attendance (usually one page) for each listing noted above to add up to 30 contact hours. Please refer to N.J.A.C. 13:37-5.3 for information regarding approved C.E.U. providers. Please note: The required 30 C.E.U.'s must be related to Nursing. (www.NJConsumerAffairs.gov)



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Dear Applicant:

In November 2003, legislation was passed that requires the Division of Consumer Affairs to conduct criminal history record background checks on all health care professionals prior to the issuance of an initial license or other authorization to practice a health care profession (N.J.S.A. 45: 1-28 et seq.). The records of the Division show that you are a current applicant for licensure or certification as a health care professional, and as such, the Division must arrange to conduct a criminal history check of your background.

In order for the Division to conduct a criminal history record background check, you must complete the enclosed Certification and Authorization form and return it to the mailing address above.

(In-State Applicants)

Upon receipt of the completed Certification and Authorization form, the Board will ***forward*** your information about how to schedule an appointment with MorphoTrust, Inc., to have your fingerprints electronically recorded. ***A \$65.45 fingerprinting fee must be paid to MorphoTrust, at the time of fingerprinting.*** The \$65.45 payment should be in the form of a check or money order made payable to MorphoTrust.

(Out-of-State Applicants)

Upon receipt of the completed Certification and Authorization form, the Board will ***forward*** you one state and one federal fingerprint card. Out-of-state applicants must have their fingerprints recorded, on the cards provided, by their local police department, by their state police department or by their local law enforcement agency. You must return the fingerprint cards to the Board or Committee with the required fee. Applicants submitting fingerprint cards will be required to pay a \$61.44 fee to have their fingerprints scanned into the electronic system by MorphoTrust. ***The \$61.44 should be in the form of a check or money order made payable to MorphoTrust.***

If you fail to complete and return the Certification and Authorization form, your application for licensure or certification will not be processed and your application will be considered abandoned.

The New Jersey Board of Nursing

CERTIFICATION

I, _____, in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Signature of applicant

Date